Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2489AGC	A. BUILDING _____ B. WING _____	07/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANCELLOR GARDENS OF THE LAKE	2620 LAKE SAHARA DRIVE LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of a complaint investigation State Licensure survey conducted at your facility 6/12/09 nd completed on 7/29/09. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for a total of one hundred & fifty (150) Residential Facility for Group beds. One hundred twenty beds for elderly and disabled persons, chronic illnesses and thirty (30) beds which provides care to persons with Alzheimer's, Category II residents. The census at the time of the survey was eighty-two (82) residents. 8 resident files were reviewed. One discharged resident file was reviewed. Complaint #NV00022179 was substantiated see TAG #Y 515 Complaint #NV00022241 was substantiated see TAG # Y 883, Y515 Complaint #NV00022535 was substantiated see TAG # Y 22535 The following deficiencies were identified	Y 000		
Y 515 SS=K	449.259(1)(a) Supervision of Residents NAC 449.259 1. A residential facility shall:	Y 515		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Y 515	Continued From page 1 (a) Provide each resident with protective supervision as necessary. This Regulation is not met as evidenced by: Based on record review and interview, the facility failed to provide protective supervision as necessary for 2 of 9 sampled residents (Resident #4, #5). Findings include: 1. Resident #4 was a 72 year old male admitted to the facility on 5/23/07 with the diagnoses of diabetes, hypertension, anemia, post traumatic stress disorder, social phobia, panic disorder and generalized anxiety disorder. Interview on 7/21/09 with Resident #4's family member, indicated that on 7/16/08, the family received a call from the facility at 11:00PM, informing them that at approximately 2:00PM, their father had gone missing from the facility. It was the family members opinion, that the staff was not watching the resident at the time he eloped. The facility notified the police upon the request of the family at 12:00PM. The resident was found by construction workers approximately four (4) miles from the facility under a trailer at a construction site, five days later, on 7/21/08. The family member indicated that the resident was dehydrated and in a diabetic coma. She stated the resident was transported to the hospital, where he expired due to cardiac arrest and dehydration. The facility's current Executive Director reported on 6/15/09 that she had knowledge of Resident	Y 515		

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Y 515	Continued From page 2 #4's elopement from the facility on 7/16/08 and that he was found at a construction site in a diabetic coma and later expired. The Executive Director was unable to locate an incident report or discharge/transfer records for the resident. She also did not have any documented evidence that the incident was reported to the Bureau of Healthcare Quality & Compliance or Division for Aging Services. 2. Resident #5 was admitted to the facility on 5/5/09 with diagnoses of hypertension, delusional disorder- mixed type. Review of the resident's file indicated that the resident was ambulatory and independent with 90% of activities of daily living, alert and oriented to 3 of 3 spheres of person, place and time. The physician indicated on the Standard Placement Determination form dated 5/16/09, the resident would need care and protective supervision due to her mental illness. On 6/12/09 at 3:47PM, interview with the Executive Director, indicated that the resident's daughter and the facility came to a mutual agreement to place the resident in a locked memory care unit, even though the resident suffered from mental illness. The Executive Director reported that on 5/21/09, while the resident was outside on the porch of the memory care unit, the resident stood on a chair, jumped over a fence and eloped from the facility. The resident was found later in the day, unharmed at the office of Division for Aging Services. The facility failed to provide adequate protective supervision to prevent the elopement of two (2) residents. As a result of the elopement, one (1) of the residents died. Complaint # NV00022179 was substantiated.	Y 515		

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Y 515	Continued From page 3 Complaint # NV00022241 was substantiated. Severity: 4 Scope: 1	Y 515		
Y 853 SS=D	449.274(3)(a) Medical Care / Records NAC 449.274 3. A written record of all accidents, injuries and illnesses of the resident which occur in the facility must be made by the caregiver who first discovers the accident, injury or illness. the record must include: (a) The date and time of the accident or injury or the date and time that the illness was discovered. This record must accompany the resident if he is transferred to another facility. This Regulation is not met as evidenced by: Based on interview and record review, the facility failed to maintain a record of injuries, accidents or injuries at the facility for 1 of 9 sampled residents. Refer to Tag Y515. Severity: 2 Scope: 1	Y 853		
Y 883 SS=E	449.2742(7) Medication / Resident Refusal NAC 449.2742 7. If a resident refuses, or otherwise misses, and administration of medication, a physician must be notified within 12 hours after the dose is refused or missed.	Y 883		

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Y 883	Continued From page 4 This Regulation is not met as evidenced by: Based on record review on 6/12/09 & 6/15/09, the facility failed to notify a physician within 12 hours after a medication dose was refused or missed by 2 of 9 sampled residents (Resident #3 and #9). Findings include: Resident #3: The resident was a 78 year old male admitted to the facility on 8/15/09 with diagnoses of hypertension, dementia and Parkinson disease. Review of the medication administration record (MAR) for Resident #3 revealed that the resident refused medications on 5/23, 5/24, 5/25, 6/2, 6/3, 6/4, 6/7, 6/8, 6/10, 6/11, 6/13 and 6/15 of 2009. Further review of the MAR revealed that on 5/26, 5/27 and 6/1 of 2009 the resident's Seroquel 25mg, was documented as "unavailable". There was no documented evidence that the facility notified the physician of the resident's refusal to take his medications. Resident #9: The resident was admitted to the facility on 5/29/09 with diagnoses of hypertension, diverticulitis, anemia, coronary artery disease, dementia and history of urethral cancer. The resident was admitted to the facility with the following documented medications: Flomax 0.4mg, Lisinopril 20mg, Aspir -low 81mg, Ferrous/sulf 324mg, Omeprazole 20mg, Lexapro 10mg, Atenolol 25mg, Aricept 10mg and Plavix 75mg.	Y 883		

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Y 883	Continued From page 5 On 7/24/09 at 4:13PM, interview with the Wellness Coordinator indicated that Resident #9 had refused his medication from 5/29/09 through 6/16/09. The facility notified a physician on 6/16/09 of the residents refusal to take medications and a order dated 6/16/09 was written to discontinue all medications. On 7/29/09 at 1:15PM, interview with the Physician reported that he was not Resident #9's primary physician and he had only seen, the resident one (1) time on 6/16/09 at the request of the facility. It was also reported that prior to 6/16/09, the Physician had no knowledge of the resident's medication refusal. The June 2009 MAR for Resident #9 had the dates of 6/8/09 -6/16/09 initialed and circled. Interview with the Licensed Practical Nurse (LPN) indicated that the initialed and circled dates on the MAR documented the resident's medication refusal. The MAR was blank for the dates 6/1/09-6/7/09 and there was no indication whether the resident was administered medications or refused his medications. Although, on 7/24/09, the Wellness Coordinator indicated that the resident had refused all medication from 5/29/09 through 6/16/06. Resident #9 refused his medications for approximately 16 days before the facility notified a physician. The facility failed to notify the Physician within 12 hours of 2 of 9 sampled residents refusing an administration of medication. Complaint # NV00022241 Complaint # NV00022535	Y 883		

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Y 883	Continued From page 6 Severity: 2 Scope: 2	Y 883		